ARTICLE 14

SECTION 4

PROOF OF MEDI-CAL ELIGIBILITY AND THE PROVIDER'S RESPONSIBILITY

1. GENERAL

This section provides the State Department of Health Services' policy regarding a provider's use of the Medi-Cal eligibility verification process, and the provider's subsequent obligation to render services in accordance with Medi-Cal program requirements. ACWDL 95-76

2. BACKGROUND

With the implementation of the Benefits Identification Card (BIC), a medical provider may use several access methods to verify a client's eligibility for Medi-Cal. These include using the on-line Point of Service (POS) device, Claims and Eligibility System and telephone Automated Eligibility Verification System. Under state law, when a provider elects to verify eligibility by using the BIC (or taking a label or photocopying a paper identification card), the provider has obtained proof of eligibility and thus has agreed to accept the client as a Medi-Cal patient and is bound by the rules and regulations of the Medi-Cal program.

3. STATE POLICY

If the eligibility verification indicates that the client is eligible to receive the provider's services, the provider cannot then treat the client as a private pay patient because the provider is unwilling to bill the client's insurance, obtain a Treatment Authorization Request or comply with any other program requirement. In addition, having obtained eligibility verification, the provider cannot bill the client for all or part of the charge of a Medi-Cal covered service except to collect the Medi-Cal co-payments or share-of-cost. This means Medi-Cal providers may not bill the client for private insurance cost sharing amounts, such as deductibles, coinsurance or co-payments.

There are situations when the provider may decline to treat the client as a Medi-Cal patient after requesting eligibility verification. These situations include:

A. The client has refused to pay the required share-of-cost.

B. The client has only limited Medi-Cal benefits, preventing the provider from rendering services (e.g., the client is eligible for pregnancy-related services only).

C. The client must receive services from a designated health plan either because he/she is enrolled in a Medi-Cal Managed Care Plan or has private insurance through a Health Maintenance Organization or exclusive provider network, and the provider is not a member of the health plan.

D. The provider cannot provide the particular services the client requires.

E. The client is not eligible for Medi-Cal.

F. The client is not able to present corroborating identification to verify that he/she is the individual to whom the BIC was issued.

A provider may decline to accept Medi-Cal patients, but must do so before accessing eligibility information, except in the situations noted above. If a provider is unwilling to accept the beneficiary as a Medi-Cal patient, the provider has no authority to access confidential eligibility information.

In addition, a provider cannot treat beneficiaries eligible for both Medicare and Medi-Cal as if they were eligible only for Medicare, thereby making the beneficiaries obligated to pay deductibles and coinsurance. In 1983, United States District Court decision, Samuel v. California Department of Health Services, the court held that because the Department pays the Medicare premium for Medi-Cal beneficiaries, the provider must accept the Medicare eligible's Medi-Cal eligibility. They cannot bill the beneficiaries for the Medicare coinsurance and deductible amount since state law precludes providers from seeking reimbursement from the beneficiary.

If a beneficiary is being billed for Medi-Cal covered services, the beneficiary should contact Data Systems' Beneficiary Billing Unit at (916) 636-1980 for assistance.